STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155236	A. BUILDING 00 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVON HEALTH & REHABILITATION CENTER	4171 FOREST POINTE CIRCLE AVON, IN46123

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F0000	This visit was for investigation of complaint number IN00094500. Complaint IN00094500: Unsubstantiated due to lack of evidence Unrelated deficiencies cited at F272, F279 and F320 Survey dates: September 1, 2 and 7, 2011 Facility number: 000141 Provider number: 155236 AIM number: 100283860 Survey team: Vanda Phelps, RN Census bed type: 130 SNF/NF 130 Total Census payor type: 13 Medicare 90 Medicaid 27 Other 130 Total Sample: 6 These deficiencies also reflect state findings cited in accordance with 410	F0000	This plan of correction is prepared and executed because it is required by the Provisions of State and Federal Law, and not because Avon Health and Rehabilitation Center agrees with the allegations contained there in. Avon Health and Rehabilitation Center maintains that each deficiency does not jeopardize the health and safety of the residents, nor is it of such character as to limit our capability to provide adequate care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	IAC 16.2. Quality review completed 9/9/11 Cathy Emswiller RN			
F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on observation, record review and interviews, the facility failed to assess 1 of 6 sampled residents for potential causative medical conditions when he developed a serious behavior impacting	F0272	I. Resident E's medications reviewed by physician, with new orders received for Tramadol. Residents BIMS, Mood/ behavior, communication, and pain assessments updated. II. All	09/28/2011

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	both he and his peers. (Resident E) Findings include: Resident E was observed sitting in the unit lounge with multiple residents on 9/1/11 between 5:15 p.m. and 7:30 p.m. He was heard verbalizing noises which were not words for extended periods of time. He would be quiet for a few minutes and then start again. Staff were observed in the area and were not attempting to engage him in distractions of any kind or to inquire as to his comfort. His peers were quiet at the time. The television was playing. They had just finished their evening meal. Resident E's clinical record was reviewed on 9/2/2011 at 12 p.m. It indicated he had been admitted to the facility's locked dementia unit two years ago, on 8/27/2011. His diagnoses included, but were not limited to, Alzheimer's dementia and osteoarthritis. Nursing notes were reviewed from 2/14/11 through 9/2/11. A nursing note dated 3/1/11 at 11:05 a.m. indicated Resident E was going down the hall loudly verbalizing "ba-ba-ba-ba." This was the first mention of this type of behavior. From that point forward, the nursing notes indicated he did this with increasing frequency and at times so irritated his		residents exhibiting behaviors that are disruptive to other residents such as loud, repetitive verbalizations who have the potential to be affected. See #3 III. Social services to review charting daily to review “behavior data collection tool” in efforts to capture behaviors impacting residents and their peers. This will be noted on a “daily log”. IV. DON or designee will review “daily log” of behaviors. This will occur with DON or designee auditing 3 residents notes weekly x 3 months to ensure capture of “like behaviors” on “daily log”. Then auditing 3 residents notes monthly until compliance is met and the remain on ongoing observation for QA review. V. Completion date: September 28,2011	

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	peers they would yell at him to be quiet and on three occasions since 7/15/11 a peer became so irritated she had smacked him because he was being noisy. This had been repeated on 8/2/11 and again 8/23/11. Resident E's 7/25/11 quarterly Minimum Data Set assessment indicated he had impaired short and long memory and was severely impaired regarding safety issues. He was unable to answer questions for a BIMS test (Brief Interview of Mental Status). He was dependent on staff for his daily care, but could walk independently with minimal assistance of one staff member. The 7/25/11 quarterly assessment was the last one on file. It did not identify this troublesome behavior. The record did not reflect efforts to determine what might have caused the change in his behavior. A psychiatrist had been consulted, but offered only psychoactive medications in increasing doses to calm him rather than an assessment to determine if a clinical issue was causing the loud verbalizations. Review of these progress notes indicated they lacked instructions or suggestions to the hands-on staff in how to reduce the frequency or magnitude the episodes of verbalizing loudly. The record also lacked assessments to determine if pain			

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	was a factor in this behavior. Evidence was lacking the attending physician had been asked for assistance in assessing Resident E's change in behavior. Interview with the Administrator, Director of Nursing and Social Worker 9/2/11 at 2:50 p.m. indicated they had not considered Resident E's loud verbalizations more than an advancement in his dementia. They indicated they relied on the psychiatrist's medicinal interventions to reduce Resident E's loud behavior and believed the medication dose increase of 8/10/11 had not taken effect as yet. Further assessments had not been done. 3.1-31(c)(3) 3.1-31(c)(4)			

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation and record review the facility failed to develop a care plan which helped guide hands-on staff to effectively intervene when the loud vocalizations of 1 of 6 sampled residents continued to the point of causing increased agitation and aggression in his peers. (Resident E) Findings include: Resident E's clinical record was reviewed on 9/2/2011 at 12 p.m. It indicated he had been admitted to the facility's locked dementia unit two years ago. His diagnoses included, but were not limited to, Alzheimer's dementia and	F0279	I. Resident E's care plan reviewed and Updated. II. All residents exhibiting behaviors that are disruptive to other residents such as loud, repetitive verbalizations who have the potential to be affected. See #3 III. Social Services, with the review of the "Behavior data collection tool", will review and update care plans of residents with potential behaviors impacting residents and their peers during the interdisciplinary team meeting daily. IV. DON or designee will review updated care plans for needs met. This will occur with DON or designee auditing 3 residents updated Care plans weekly x 3 months to ensure appropriateness of plan. Then auditing 3 residents updated care	09/28/2011

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	osteoarthritis. Nursing notes were reviewed back through 2/14/11. An entry dated 3/1/11 at 11:05 a.m. indicated Resident E was going down the hall loudly verbalizing "ba-ba-ba-ba." This was the first mention of this type of behavior. From that point forward, the nursing notes indicated he did this with increasing frequency and at times so irritated his peers they would yell at him to be quiet and on three occasions since 7/15/11, a peer became so irritated she had smacked him because he was being noisy. Examples, not inclusive of all: A. 7/15/11 4:35 p.m.: Resident E was being "loud" while sitting in the lounge. A female peer slapped his arm sternly and told him to "shut up." B. 7/25/11 at 4:24 a.m.: "Resident has been awake all night. Wanders between the lounge and dining areas...Becomes loud at times...no distress noted." C. 7/29/11 at 5:56 a.m.: "Resident awakened at 2330 [11:30 p.m.]. He has been awake all night...Loud verbalizations at times...." D. 8/2/11 at 11:01 p.m.: Resident was sitting in lounge, he was making loud verbalizations and female resident spoke very loudly would you be quiet and she		plans monthly until compliance is met and then remain ongoing observation for QA review. V. Completion date: September 28, 2011	

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	slapped him on his left forearm, he was even louder for a moment and then he was quiet. separated the two and no more issues." E. 8/23/11 at 6:10 p.m.: "resident was being verbally loud and walking in front of female peer. female peer told him to shut up and reached up and smacked him on the left arm, activities person asked female peer to please not smack him and she then removed resident from area, no injuries." Review of the current care plan within the electronic chart indicated an entry addressed this issue. The problem was stated in combination with other behavioral issues: "Repetitive verbalizations disruptive to peers, restlessness and easily angered/resistive with care attempts." The goal was not geared to Resident E: "Resident will not cause distress to peers." The interventions were: "attempt to decrease environmental stimuli by taking to quieter area, assess for unmet needs such as pericare/toileting, snack/drink, need to lay down, etc. follow up with psych services, offer resident sweet snack such as ice cream or candy, provide resident meals in the quieter/less excessively stimulating lounge area, provide one on one attention as able such			

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	as holding resident's hand or just sitting next to him and talking." This entry had not been revised since 6/7/11. Review on 9/2/11 at 2:30 p.m. indicated the current CNA (certified nurse aide) information sheet did not mention the issue. Resident E was observed sitting in the dementia unit TV lounge with multiple peers on 9/1/11 between 5:15 p.m. and 7:30 p.m. He was heard verbalizing noises which were not words for extended periods of time. He would be quiet for a few minutes and then start again. Staff were observed in the area and were not attempting interventions to distract him or stop the behavior. 3.1-35(b)(1)			
F0320 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable. Based on observation, record review and interviews, the facility failed to	F0320	I. Resident E assessed by Physician on September 2, 2011 with an adjustment in pain	09/28/2011

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	investigate for potentially causative reasons within the resident's clinical condition when he suddenly began to display frequent, loud verbalizations for extended periods of time, which then caused his peers to become irritable and agitated, also making him a potential target of resident to resident altercations . This impacted 1 of 6 residents sampled for behaviors in the total sample of 6. (Resident E) Findings include: Resident E's clinical record was reviewed on 9/2/2011 at 12 p.m. It indicated he had been admitted to the facility's locked dementia unit two years ago, on 8/27/2011. His diagnoses included, but were not limited to, Alzheimer's dementia and osteoarthritis. A nursing note dated 3/1/11 at 11:05 a.m. indicated Resident E was going down the hall loudly verbalizing "ba-ba-ba-ba." The notes were reviewed back through 2/14/11 with 3/1/11 being the first mention of this type of behavior. From that point forward, the nursing notes indicated he did this with increasing frequency and at times so irritated his peers they would yell at him to be quiet. On three occasions within the last six weeks, a peer became so irritated she had smacked him because he was being noisy. Examples, not		medication. Subsequent adjustments ongoing as warrented by physician. II. All residents with like behaviors (loud, repetitive verbalizations)that are unable to communicate complaints have the potential to be affected. See #3 III. Social services to review charting daily to review “behavior data collection tool” in efforts to capture behaviors impacting residents and their peers. This will be noted on a “daily log”. Social Services, with the review of the “Behavior data collection tool”, will review and update care plans of residents with potential behaviors impacting residents and their peers during the interdisciplinary team meeting daily. IV. DON or designee will review “daily log” of behaviors and updated care plans. This will occur with DON or designee auditing 3 residents notes/care plans weekly x 3 months to ensure capture of “like behaviors” on “daily log”. Then auditing 3 residents notes/care plans monthly until compliance is met and the remain on ongoing observation for QA review. V. Completion date: September 28, 2011	

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	inclusive of all: A. 7/15/11 4:35 p.m.: Resident E was being "loud" while sitting in the lounge. A female peer slapped his arm sternly and told him to "shut up." B. 7/25/11 at 4:24 a.m.: "Resident has been awake all night. Wanders between the lounge and dining areas...Becomes loud at times...no distress noted." C. 7/29/11 at 5:56 a.m.: "Resident awakened at 2330. He has been awake all night...Loud verbalizations at times...." D. 8/2/11 at 23:01 p.m.: Resident was sitting in lounge, he was making loud verbalizations and female resident spoke very loudly would you be quiet and she slapped him on his left forearm, he was even louder for a moment and then he was quiet. separated the two and no more issues." E. 8/23/11 at 18:10 p.m.: "resident was being verbally loud and walking in front of female peer. female peer told him to shut up and reached up and smacked him on the left arm, activities person asked female peer to please not smack him and she then removed resident from area, no injuries."			

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	Resident E was observed sitting in the unit lounge with multiple residents on 9/1/11 between 5:15 p.m. and 7:30 p.m. He was heard verbalizing noises which were not words for extended periods of time. He would be quiet for a few minutes and then start again. Staff were observed in the area and were not attempting to engage him in distractions of any kind or to inquire as to his comfort. His peers were quiet at the time. The television was playing. They had just finished their evening meal. Resident E's 7/25/11 quarterly Minimum Data Set assessment indicated he had impaired short and long memory and was severely impaired regarding safety issues. He was unable to answer questions for a BIMS test (Brief Interview of Mental Status). He was dependent on staff for his daily care, but could walk independently with minimal assistance of one staff member. The record did not reflect efforts to determine what might have caused the change in his behavior. A psychiatrist had been consulted, but offered only psychoactive medications to calm him rather than an assessment to determine if a clinical issue was causing the loud verbalizations. Review of these progress notes indicated they lacked instructions to			

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	the hands-on staff in how to reduce the frequency or magnitude of his episodes of verbalizing loudly. The record also lacked assessments of potentially painful medical issues although osteoarthritis was listed as a diagnosis. They acknowledged questioning Resident E about pain could not produce reliable information. The resident could not tell them and if he did say yes or no, his accuracy was in doubt. Interview with the Administrator, Director of Nursing and Social Worker 9/2/11 at 2:50 p.m. indicated they had not considered Resident E's loud verbalizations more than an advancement in his dementia. They indicated they relied on the psychiatrist's medicinal interventions to reduce Resident E's loud behavior and believed the medication dose increase of 8/10/11 had not taken effect as yet. They indicated Resident E was routinely receiving Tylenol four times daily for his arthritis as that was what his family had told them worked well . Therefore they assumed, because of lack of overt symptoms of pain, there was no need to further address that issue. Evidence was lacking the attending physician had been asked for assistance in assessing Resident E's change in behavior.			

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	The 8/10/11 psychiatrist's progress note indicated he was requested to see Resident E due to "more disruptive with loud vocalizations, wandering, (arrow up) c (with) noc (night) wanders." The M.D. had written "behavior is worse from noon till bed time--other residents are telling him to shut-up." Resident E had been receiving the antipsychotic medication Zyprexa 5 milligrams daily at 5 pm since 4/11/11. On 8/10/11, the dose was increased to Zyprexa 7.5 milligrams at 5 p.m. daily. 3.1-43(a)(1)			